CENTERS FOR MEDICARE & MEDICAID SERVICES

10/13/2011 PRINTED: FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G741		A. BUILI B. WING	DING	00	COMPL 09/16/2	LETED	
NAME OF I	PROVIDER OR SUPPLIER		P. WIII.	STREET A	ADDRESS, CITY, STATE, ZIP CODE RENTMAN ROAD VAYNE, IN46816	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
l	This visit was fundamental recertification licensure sure 13, 14, 15, and Provider Number 13 and Number 14 and Number 15 and Number 15 and Number 16 and Number 17 and Number 17 and Number 18 and Number 19 and Num	us for the annual n and state vey.  Vey: September and 16, 2011.  Imber: 15G741 aber: 011504 ar: 200889050 are already and the control of the		I	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	
	findings in a 431 IAC 1.1 Quality Revi 9/23/11 by C ICF-ID Surv	ccordance with					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K01Y11

Facility ID:

011504

		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G741	B. WING		09/16/2011
NAME OF P	ROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE	
AWS				RENTMAN ROAD	
			FORT	WAYNE, IN46816	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAG			IAG	1	DATE
	Surveyor III.	•			
W0316	Drugs used for cor	ntrol of inappropriate			
W 0310	_	gradually withdrawn at least			
	annually.	g			
			W0316	W 316- A statement from the	10/10/2011
	Based on record revi	iew and interview, for 2 of 2		psychiatrist has been obtaine	l l
		ents #1 and #2) who received		client #1 and client #2 that the	• • • • • • • • • • • • • • • • • • •
		ations, the facility failed to		is a contraindication in making any medication reductions a	•
	evaluate each client's	s status for an annual decrease		time for the clients. The	
	or contraindication of	of psychotropic medication of		Psychotropic Medication Re	view
	a decrease.			form has been updated to in	clude
	Finding to 1 4.			a checkbox to prompt the	
	Findings include:			psychiatrist to complete that section of the PMR more	
	1 Client #1's record	d was reviewed on 9/14/11 at		thoroughly to meet the	
		's 3/9/11 ISP (Individual		requirements. The nurse,	
		ated a 3/10/11 Behavior		manager, QMRP and Behav	ior
	Support Program (B	SP) which indicated client #1		Analyst have also received	
		ors of physical aggression, Self		training on monitoring the	· c
	,	SIB), and Non Compliance.		comments, ensuring that sec of the PMR has been comple	
		cated the use of Risperdal 6mg aviors "increased from 4mg in		appropriately and comments	l l
		uel 100mg for behaviors		included as needed on the	
	"added 10/2009."	der roomg for benaviors		Behavior Monthly Report. T	
				Residential Director will mon	• • • • • • • • • • • • • • • • • • •
	Client #1's record in	dicated 4/11/11 and 1/12/11		compliance by participation i	n the
		ation reviews and client #1's		Behavior Support Monthly meeting and by reviewing th	_
		011, and 5/2011 monthly		PMR's.	
	_	did not indicate a change or			
	contraindication of c	change of client #1's ations. No reason was			
		#1's record did not include a			
		or an annual decrease or			
		decrease of client #1's			
					I

STATEMENT OF DEFICIENCIES (X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED
		15G741	- 1			09/16/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L				
				1	RENTMAN ROAD	
AWS	AVVS			FORT	VAYNE, IN46816	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE
	psychotropic medica	ation. Client #1's record did				
	not indicate the last medication change or					
	contraindication con					
	2. Client #2's recor	rd was reviewed on 9/14/11 at				
	11:40am. Client #2'	's 3/16/11 ISP (Individual				
	Support Plan) indica	ated a 3/22/11 Behavior				
	* *	SSP) which indicated client #2				
		ors of physical aggression,				
	-	l Self Injurious Behavior				
	(SIB). Client #2's p	lan indicated the use of				
	Risperdal 4mg for b	ehaviors and Depakene				
	3,000mg for behavio	ors, and no start date was				
	indicated. Client #2	's 8/2/11 "Physician's Order"				
	and 8/3/11 "Psychot	ropic Medication Review"				
	both indicated "8/24	1/2000 Risperdal 1mg 1 tab				
	(tablet) 4 x (four time	nes) daily" and "2010				
	Depakote 1,000mg	TID (three times a day)."				
		ndicated 8/13/11, 5/2/11,				
	2/4/11, and 11/3/10	psychotropic medication				
		2's 8/2011, 7/2011, 6/2011,				
		"Behavior Meeting" did not				
	_	contraindication of change of				
		opic medications. No reason				
		Client #2's record did not				
		aluation for an annual decrease				
		of decrease of client #2's				
	* *	ation. Client #2's record did				
		medication change or				
	contraindication con	nsidered.				
	00/14/11 + 1.22					
		m, an interview with				
		(RD) #3 was completed. RD				
		itional information was				
		to determine if client #1 and				
		edications were evaluated for				
	an annual decrease of					
		D #3 stated client #1 and #2's				
	records indicated ea	ch client was "stable" for				
	1		1			ı

011504

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED
		15G741	B. WING		09/16/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			RENTMAN ROAD	
AWS				NAYNE, IN46816	
Ανο			TOKIN		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	behaviors.				
		am, an interview with RD #3			
		#3 provided a 9/14/11			
		ndication from client #1 and			
		D #3 indicated client #1 and			
		edications were not evaluated			
	for a decrease or contraindication until the surveyor inquired on 9/14/11.				
	surveyor inquired of	1 // 1 7/ 11.			
	1.1-3-5(a)				
	1.1 5 5 (4)				
W0382	The facility must keep all drugs and biologicals locked except when being				
110302					
	prepared for admir	red for administration.			
			W0382	W382- All staff have been	10/16/2011
	Based on observation, record review, and			re-trained on the Medication	
		interview, for 4 of 4 clients (clients #1, #2, #3, and		Administration and Storage	
	#4), the facility faile	ed to maintain proper		Medication policies including their responsibility to secure	j their
	medication security.				
				medications so they are not	
	Findings include:			accessible by clients in the home. The Manager and Nu	ureo
				are conducting an observation	
		50pm until 4:40pm, the		medication passes with each	
		was observed unlocked and		member of the home and wi	
	accessible above the washer/dryer inside the laundry room. From 2:50pm until 4:40pm, clients			complete spot checks therea	
				This will be documented on	
		vere observed to independently		Medication Observation and	l l
	-	indry room to use the		submitted to the Residential	
	connecting bathroom, sort their laundry, change			Director for review and to me	onitor
	-	from the washer/dryer, wash		compliance.	
their hands in the sink in					
		ch held medications for clients ras unlocked and unsecured.			
	, , ,	indicated she did not unlock			
	_	net before she began			
		tration because the cabinet was			
		indicated medications were			
		ocked cabinet. DCS #1 stated			
	ansecured in the uni	conce cuomet. Deb mi stated			

011504

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		15G741	B. WING			09/16/2	011
NAME OF D	ROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE	<del></del>	
NAME OF P	ROVIDER OR SUPPLIER			9824 TF	RENTMAN ROAD		
AWS				FORT V	VAYNE, IN46816		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ould have been locked" and	+	TAG	DLI ICILIACI )		DATE
		nd #4 had access to the					
	unsecured medication						
		onducted on 9/14/11 at 1:30pm,					
		rector (RD) #2 and RD #3. RD					
		l "all" medications should be					
	locked when unattended by staff.						
	1.1-3-6(a)						
W0202	Only authorized pe	ersons may have access to					
W0383	the keys to the dru						
			W0383 W383- All staff have been				10/16/2011
	Based on observation, record review, and interview, the facility failed to secure and		'''	0505	re-trained on the Medication		10/10/2011
					_	Administration and Storage of	
		access to the medication			Medication policies including	their	
	•	4 of 4 clients (#1, #2, #3,			responsibility to secure medications so they are not		
	and #4) who resi	* * * * *			accessible by clients in the		
	and #4) who iesi	ded in the nome.			home. The Manager and Nurse		
	Findings include				are conducting an observation		
	r manigs merade	•			medication passes with each staff member of the home and will		
	On 9/13/11 from	2:50pm until 5:30pm,			complete spot checks therea		
		interview at the group			This will be documented on a		
		pleted with clients #1, #2,			Medication Observation and be	be	
	•	(Direct Care Staff) #1.			submitted to the Residential Director for review and to mo	onitor	
		til 5:30pm, two (2) rings			compliance.		
	-				,		
		binet keys was observed					
	on top of the wall mounted fire box inside the laundry room at eye level and beside						
		abinet. From 2:50pm					
	_	ents #1, #2, #3, and #4					
		independently walk					
		dry room to use the					
connecting bathroom, sort their laundry,							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G741		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/16/2011	
NAME OF PROVIDER OR SUPPLIER  AWS			STREET A 9824 TF	ADDRESS, CITY, STATE, ZIP CODE RENTMAN ROAD VAYNE, IN46816	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	washer/dryer, and sink inside the late DCS #1 stated the medication cabine eye level fire box indicated the medicated was a secured medical.  An interview was 1:30pm, with Re #2 and RD #3. For "all" medication secured when medicated when medicated when medicated RI #2, #3, and #4 has medication keys cabinet.  On 9/14/11 at 1:2 the facility's undared Community" Community "Community" Community "Community" Community "Community "Community" Community "Community "Comm	s conducted on 9/14/11 at sidential Director (RD) RD #2 and RD #3 stated keys should be kept edications were not D #2 indicated clients #1, ad access to the to the medication  45pm, a record review of ated "Living in the re A/Core B training for nistration indicated "Core bles of Administering dication cabinet keys			

STATEMENT OF DEFICIENCIES (X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	DING	00	COMPLETED	
		15G741	A. BUILDING B. WING 09/16/2011			011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	RENTMAN ROAD		
AWS				1	WAYNE, IN46816		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
TAG W0436	The facility must for repair, and teach of informed choices a eyeglasses, hearing communications and evices identified as needed by the desired as	curnish, maintain in good clients to use and to make about the use of dentures, and and other ids, braces, and other by the interdisciplinary team client.  Cation, record review, and of 2 clients (client #2) ibed eyeglasses, the encourage and teach his prescribed eye  C2:50pm until 5:30pm, com 5:40am until 8am, interview were completed e. Client #2 did not wear e glasses. During both ods client #2 watched he menu with staff, put colored outside the lines de, walked in the	W	0436	W436- All staff have received re-training to encourage clier to wear his glasses. The QN has added a goal to client #2 ISP to assist the individual ar the staff in teaching client #2 importance of wearing his glasses. The Residential Mc Reports will be monitored by Residential Director to ensurthat the training is effective a that client #2 is wearing his glasses.	nt #2 MRP I's nd the onthly the e	10/16/2011
	indicated a 8/22/						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  15G741		(X2) MULTIPLE ( A. BUILDING B. WING	00	09/16/2	LETED	
NAME OF P	ROVIDER OR SUPPLIEF		9824	TADDRESS, CITY, STATE, ZIP CO TRENTMAN ROAD WAYNE, IN46816	DE .	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		
	evaluation which prescribed eye g 3/16/11 ISP (Indinot indicate an orglasses.  An interview was 1:30pm, with Reference with the second prescribed eye g RD #2 indicated objective to teach glasses.  On 9/16/11 at 10 RD #3 was complicated an objective to wear his glass objective develo	in indicated client #2 wore classes. Client #2's ividual Support Plan) did bjective to wear his eye as conducted on 9/14/11 at esidential Director (RD) RD #2 and RD #3 #2 should have been araged to wear his client #2 did not have an his client #2 to wear his client #2 to wear his assess and stated client #2 "now" to teach client #2 es. RD #3 provided an ped on 9/15/11 for client the table to wear his eye				DATE